STATEMENT

of the

American Medical Association

to the

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

RE: Current Hospital Issues in the Medicare Program

May 20, 2014

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The American Medical Association (AMA) is pleased to provide the Subcommittee on Health of the Committee on Ways & Means with our views on Medicare's two-midnight policy, short inpatient stays, outpatient observation stays, auditing, and appeals. As a threshold matter, we urge the Subcommittee to consider that these issues significantly affect physicians as well as hospitals. These issues have raised considerable interest among our members and state and specialty medical societies. We look forward to continuing to provide the physician perspective as the Subcommittee examines these important issues.

Two-Midnight Policy

The AMA opposes Medicare's two-midnight policy and believes it should be rescinded in its entirety.[1] Under the policy, Medicare contractors presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who exceed the two-midnight benchmark. In addition, Medicare contractors must now presume that hospital services spanning less than two midnights should have been provided on an outpatient basis. While stays for less than two midnights may be deemed properly inpatient if there is clear documentation in the medical record to support the physician's inpatient stay order, such determinations necessitate contractor review and audit. Therefore, hospitals have a disincentive to permit such orders.

[1] AMA Letter to CMS on the Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Proposed Rules. June 25, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/inpatient-prospective-payment-systems-comment-letter-25june2013.pdf

While we understand that the Centers for Medicare & Medicaid Services (CMS) intended to provide greater clarity regarding what constitutes an inpatient stay by instituting this policy, the effect has been quite the opposite. The policy has led to much confusion for physicians who are now faced with estimating the length of stay for their patients and determining whether they would fit within the arbitrary rubric of a two-midnight stay. For example, under the policy, the visit of a patient who comes to the hospital at 1:00 a.m. on a Monday, and stays through 11:00 p.m. on Tuesday—a total of 46 hours—would be presumed by Medicare review contractors to have been properly categorized as an outpatient stay. Incongruously, the visit of a patient who comes to the hospital at 11:00 p.m. on a Monday, and stays through 1:00 a.m. on a Wednesday—a total of 26 hours—would be presumed by a Medicare review contractor to have been properly categorized as an inpatient stay.

Adding to the complexity of the two-midnight policy is the inconsistency between when a hospital stay is considered to be inpatient for purposes of hospital reimbursement versus when a patient is considered an inpatient for purposes of coverage. The policy allows Medicare contractors to count the entire length of stay, including the time prior to the inpatient order, toward meeting the two-midnight benchmark for hospital reimbursement purposes. In contrast, the patient status does not change from "outpatient" to "inpatient" until the physician inpatient order is entered. This can alter the overall cost of the stay to the patient, and can significantly affect patient coverage for services like skilled nursing facility (SNF) care, for example. Physicians who are managing the overall care of their patients while also responding to institutional concerns about audits are left trying to navigate multiple interests and divergent rules.

We also have serious concerns about the administrative burden that this policy is having on physicians. While the authority to determine whether a patient requires an inpatient level of care should remain with the physician, the numerous inpatient order and certification requirements issued by CMS via sub-regulatory guidance and multiple addenda have resulted in a tremendous amount of new, confusing rules for physicians. We have advocated that, at a minimum, CMS should actively educate physicians and hospitals in regard to compliance with these requirements. Such education should go beyond CMS open door forums and national provider calls; education is needed "on the ground" to help physicians understand the litany of these requirements and their complexity.

Short Inpatient Stays

We are pleased that CMS adopted our recommendation in its 2015 Inpatient Prospective Payment Systems (IPPS) proposed rule to explore whether the use of a short stay payment adjustment might be a vehicle to remedy the problem of increased observation care and the

related issues that this trend has caused for physicians and patients.[2] We believe that a short stay payment methodology may more appropriately reimburse services that fall below the two-midnight benchmark, lessening the pressure on hospitals to either admit a patient or place the patient in observation care.

The short stay outlier is utilized by CMS as an adjustment to the payment rate for long-term care hospital (LTCH) stays that are generally much shorter than the average length of stay for a Medicare severity long-term care diagnosis-related group. Our impression is that the use of a short stay outlier affords LTCHs the flexibility to tailor patient stays for the amount of time to most appropriately address patients' clinical needs. We will be developing more detailed recommendations on this topic over the next several months, and will share our work with the Subcommittee at that time.

Outpatient Observation Stays

There can be wide differences in cost to the patient for time spent as an outpatient under observation. For example, self-administered drugs can cost significantly more for the patient under observation than to an inpatient. In addition, there may be repercussions related to post-acute coverage. Patients who require post-hospitalization SNF care must have a prior three-day inpatient stay to qualify for Medicare coverage. While CMS has asserted that the two-midnight benchmark addresses this issue, we think that the new two-midnight policy may have exacerbated the problem, as noted earlier in this testimony.

Consider the following hypothetical: a patient presents to the hospital at 1:00 a.m. on Monday and is placed under observation. By 2:00 a.m. on Wednesday, the patient is still in need of care, and is admitted to the hospital as an inpatient. The patient does not leave the hospital until 9:00 a.m. on Thursday, and is discharged to a SNF. Since the patient was there for more than two-midnights, she will be presumed by Medicare contractors to have been properly admitted as an inpatient for purposes of hospital reimbursement. But, because she was only an inpatient from 2:00 a.m. on Wednesday until 9:00 a.m. on Thursday, it is our understanding that she will not qualify for SNF care, even though she has been in the hospital for four days.

Because of the inequity for patients of the three-day inpatient stay requirement for coverage of SNF care, we have long advocated that CMS should either rescind that policy or allow outpatient observation care days to count toward the three-day stay requirement. In that vein, we strongly support S. 569 / H.R. 1179, the "Improving Access to Medicare Coverage Act of 2013," and urge the Subcommittee to act on this important legislation.

[2] AMA and American Hospital Association Letter to CMS regarding Inpatient Admission and Review Criteria set forth in the FY 2014 Hospital Inpatient Prospective Payment System Final Rule. November 8, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/two-midnight-suspension-letter-08nov2013.pdf

Audits

Physicians are firmly committed to eradicating fraud and abuse from the federal health care programs. Monies that inappropriately flow from federal health care programs divert vital resources that should be devoted to patient care. The AMA has long believed that the most efficient way to combat fraud is to employ targeted, streamlined methods of fraud identification and enforcement, rather than overly burdensome requirements for all physicians, the majority of whom strive to comply with the rules and regulations governing participation in the Medicare program. Through this lens, we have generally been supportive of the stated goal of CMS' Center for Program Integrity to employ data analytics and targeted fraud enforcement, rather than burdensome rules and methods, to efficiently target true fraud.

We continue to have serious concerns, however, about CMS' Recovery Audit Contractor (RAC) program. RACs audit physicians in private practice and in the hospital setting, and such audits are often very disruptive and resource-intensive. They are also often erroneous: the 2011 RAC report to Congress stated that provider-appealed overpayment determinations were decided in favor of the provider 43.6 percent of the time.[3] The 2012 RAC report to Congress, which was released earlier this year, cited a figure of 26.7 percent of appeals decided in providers' favor.[4] We think this number may not be representative of RACs' accuracy because, as we discuss later in our testimony, the number of appeals at the Administrative Law Judge (ALJ) level increased dramatically during that year and were not all fully adjudicated.[5] Importantly, physicians and other providers are most likely to have decisions overturned at this level of appeal.

Because of the litany of problems with the RAC program to date, we have engaged with CMS as they revise and renew their RAC contracts for the next contract period. **In particular, we sent formal recommendations on improvements to the RAC Statement of Work (SOW) to CMS last year, such as penalties for RACs that have a high error rate or that fail to meet administrative deadlines.[6]** We were pleased that CMS recently announced some positive changes to the forthcoming SOW, such as guidelines for when RACs can receive contingency

[3] CMS. Recovery Auditing in Medicare and Medicaid for Fiscal Year 2011. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf pg. 33.

[4] CMS. Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012. March 2014. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf pg. 42.

[5] HHS. Office of Medicare Hearings and Appeals. Medicare Appellant Forum. February 12, 2014. Available at http://www.hhs.gov/omha/omha_medicare_appellant_forum_presentations.pdf (slides 15-16).

[6] AMA. Letter to CMS on the Revised RAC SOW. August 30, 2013. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/rac-program-letter-30august2013.pdf

fees for appealed claims and deadlines for provider discussion periods.[7] Many of our other recommendations, however, have not been announced by CMS as adopted in the new SOW. We are continuing our work on these issues, and welcome further dialogue with the Subcommittee on the problems our members have encountered with the RACs and legislative means by which they may be addressed.

Appeals

We are very concerned about the two-year backlog at the Office of Medicare Hearings and Appeals (OMHA), and recently sent a letter with 97 state and specialty medical societies requesting action on this issue.[8] As you are likely aware, OMHA hosted a hearing on this topic in February. During that hearing, it was apparent that OMHA is being tasked with adjudicating a record number of appeals, largely because of problems with the RAC program. Many physicians believe that they must appeal erroneous overpayment recoupments to the administrative law judges at OMHA to receive equitable and fair determinations. While OMHA laid out plans to improve processes and protocols on their end, the problem clearly lies with the RAC and other audit programs themselves. We strongly believe that CMS should take a bottom-up approach to solving this problem and revise the RAC and other audit programs as we have recommended throughout this testimony to give the requisite relief to both physician appellants and OMHA staff.

Conclusion

Thank you for giving the AMA the opportunity to share our views on these important issues. We look forward to continuing to work with the Subcommittee as you formulate your next steps.

[7] CMS. RAC Program Improvements. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf. Accessed May 15, 2014.

[8] AMA, State and Specialty Societies. Letter to OMHA regarding Appeal Backlog. February 12, 2014. Available at https://download.ama-assn.org/resources/doc/washington/x-pub/medicare-appeals-backlog-sign-on-12feb2014.pdf